A Report of a Conference

Peer Review

Cost Control or Quality Control?

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AT A TIME when the cost of medical care is soaring and the physician's time is becoming a scarce resource, doctors are finding themselves deeply involved in attempts to control hospital and nursing home costs through utilization review. Utilization review is, in general, a particular aspect of peer review in which certain groups of physicians evaluate the need for and utilization of diagnostic, therapeutic and attendant services ordered by their fellow practitioners. Unfortunately, under the influence of the Medicare and Medi-Cal programs, utilization review has, in certain instances, been limited solely to review of charges and length of stay. Review programs with this limitation fail to provide the primary raison d'être of utilization evaluations—quality control.

The California Medical Association's Utilization Review Conference on July 18, 1970, attacked this problem by presenting various alternative methods which county medical societies, hospitals and nursing homes may use for effective utilization review. The UR Conference, entitled "Utilization Review: Cost Control or Quality Control," was attended by officers and staff of county medical societies and numerous other persons concerned with this subject.

Council Policy

Shortly before the conference, CMA's Council set an affirmative tone for the day by adopting a position paper outlining the physician's review responsibilities and a philosophic blueprint for guiding development of effective UR efforts. Utilization is but one aspect of peer review, the Council paper emphasized; for several years a major objective of CMA has been to increase the effectiveness of *all* peer review activities.[1] Programs concerned with reducing medical costs, though increasingly necessary, must focus principally on the control of quality, to assure adequate and appropriate care for *all* patients, not simply the beneficiaries of government funded programs. In addition the Council expressed the opinion that local innovative approaches to UR should be encouraged—here again, though, with the aim of assuring both quality and cost control. Finally, the position paper stressed the need for a true partnership between government and private medicine in which the physician's professional competence is honored, medical care programs receive realistic funding, and the medical profession is consulted before restrictive regulations are implemented. All these issues, it was suggested, should be considered in open forum discussions between government, fiscal intermediaries, county and state medical societies, and individual physicians.

During the conference, various members of the medical profession described specific approaches to utilization review in general hospitals and in long-term care facilities. The Sacramento County Medical Society's Certified Hospital Admissions Program (CHAP) was discussed and utilization review in relation to the role of the fiscal intermediary was considered.

Dr. Ralph Burnett, president of CMA, began the conference with a presentation outlining the problems utilization review has encountered in

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California, the critical importance of involving the medical profession in effective UR programs, and the difficulties that working with the Medi-Cal program presents for both physician and patient. Dr. Burnett observed the medical profession was in a critical phase of its history during which the government was encroaching more and more on the physician's traditional role in peer review. In summary, he said that: (1) peer and utilization review originated with physicians and not politicians, (2) peer review was designed by physicians to promote appropriate care for patients and not to guarantee a balanced budget for the state or federal government, (3) physicians must be recognized as full partners in the government health care business—at the policy-making level, and (4) the medical profession must never permit the government to interfere in the processes of peer review.

UR at St. Francis Hospital

Dr. Bert Halter, chairman of CMA's Medical Staff Survey Committee, followed Dr. Burnett. Dr. Halter, a member of the staff at St. Francis Hospital in San Francisco, discussed the UR technique used at St. Francis and sketched some of his impressions on the state of UR in California hospitals. In the UR program at St. Francis Hospital, described in some detail in the August issue of CALIFORNIA MEDICINE,[2] one physician is assigned as monitor to each nursing station in the hospital for evaluating that floor's current census of patients on a daily, prospective basis. These individual monitors consider whether hospital admission was necessary, whether diagnostic procedures were needed and were instituted in an efficient and orderly manner, and whether all other aspects of the patient's care were necessary and proper. In this manner the monitors, often assisted by the ward nursing supervisor, seek to prevent both over-utilization and under-utilization; they also assist in discharge planning. If the care a patient receives is questionable, the monitor may discuss the case with the attending physician, or if necessary, report his findings to the Utilization Review Committee which meets twice monthly. The committee is composed of several physicians, the director of nursing, the hospital administrator and a recording secretary. The educational nature of the program was emphasized, although it was noted that privileges could be restricted if the committee's persuasive authority proved insufficient in "educating" an erring staff member. In Dr. Halter's opinion, UR programs in hospitals evaluated by the Medical Staff Survey Committee have, in many instances, failed to assure quality control in their respective facilities. He felt a great deal more must be done to strengthen UR activities throughout the state, warning that the time is at hand when the government may set up its own mechanisms for such reviews unless physicians, medical staffs and county societies diligently expand *all* their peer review efforts.

UR in Southern California Hospitals

Dr. Billy De Shazo, a plastic surgeon on the staff of several hospitals in Los Angeles (including California Hospital, St. Vincents, and the Hospital of the Good Samaritan) said that the California Hospital UR Committee is composed of a chairman, five permanent physician-members and 14 rotating reviewers, each of whom is assigned responsibility for a distinct hospital ward. The reviewers evaluate their ward's cases at least twice a week, writing their comments in the patient's chart when they feel the care he is receiving is unsatisfactory. If the attending physician does not respond appropriately to these comments or disagrees with the reviewer's conclusions, the UR Committee chairman will discuss his contentions with him. Instances of major over-utilization or under-utilization are referred directly to the committee as a whole for consideration. Thus, UR procedures in California Hospital differ slightly from those at St. Francis in San Francisco in that review is somewhat less frequent in the Los Angeles hospital, and the reviewers are not often directly involved in adjudicating points of disagreement with attending physicians. More fundamentally, however, in both facilities a formally designated reviewer considers the utilization of medical services that are provided all patients in an entire ward (not simply government program beneficiaries), and the UR committees in both hospitals control utilization principally through the exercise of persuasive authority. Incidentally, these two hospitals rely heavily on the professional judgment of the ward nursing supervisor. These two systems, then, are basically quite similar.

The rate of claims rejection by fiscal intermediaries operating under the Medi-Cal program seems to be increasing, Dr. DeShazo remarked.

health agencies and other health facilities would be conducted under the auspices of this managing body with appropriate support from in-house staff. The practice of concluding difficult utilization decisions by simply transferring jurisdiction would be eliminated and administrative procedures and coordinated patient discharge planning would be greatly facilitated.

- A utilization review coordinator or similar full-time staff assistant is a fundamental requirement for an effective UR program. Of course, additional administrative personnel would be needed to staff the suggested centralized review body. Access to automatic data processing services would also be essential.
- Only *one* fiscal intermediary should administer government health programs per county or review area. The current practice of multiple coverage by intermediaries has led to confusing application of rules and regulations, numerous inconsistencies, and too-frequent meetings, workshops, and the like. Creation of a single agency responsible for claims settlement would help to alleviate these problems and should improve the general public's understanding of the benefits and limitations of these programs. To this end, an intensive education program should be undertaken with extensive use of the mass media.

The Certified Hospital Admission Program

The Sacramento County Medical Society has developed a unique method for controlling and reducing the length of stay of the nearly 75,000 Medi-Cal patients in local hospitals. The significant features of this system, called the Certified Hospital Admission Program (CHAP),[4] were explained by Dr. James Bramham and Dr. James Schubert. Dr. Bramham is a practicing pediatrician in Sacramento, an officer of his county society and president of its Medical Care Foundation. Dr. Schubert, an orthopedist, is an officer of the Medical Care Foundation, and chairman of the Sacramento County Medical Society's Research and Development Committee (which developed CHAP). Dr. Bramham first took up the general issue of utilization versus quality control, and Dr. Schubert followed with a detailed analysis of CHAP.

CHAP was established originally as a means of increasing insurance benefits to include outpatient diagnostic services and treatment, psychiatric care and full coverage for hospital, surgical and maternity costs, without increase in premiums. Working with the California-Western States Life Insurance Company, the Medical Care Foundation of Sacramento determined that control of hospital costs was the single most effective way of achieving the savings necessary for this extension of benefits. CHAP was first applied to beneficiaries of one of Cal-Western's standard, non-government group health plans; and later, under a contract with the California Department of Health Care Services and Blue Shield, its coverage was broadened to include all of the region's Medi-Cal eligibles. The Medical Care Foundation has enlisted the support of the bulk of local private practitioners and Sacramento's principal hospitals.

CHAP is described as "a prospective utilization program combining preadmission and concurrent peer review to determine necessity for hospital admission and for length-of-stay." When a Medi-Cal patient or a beneficiary of a Foundation administered insurance program is about to enter a hospital for an elective procedure, his attending physician completes a certification request identifying the patient and his medical needs (by diagnosis) and mails this report to the Foundation. If the prescribed care is deemed "medically necessary," this request for certification will be approved by return mail for hospital stay up to the fiftieth percentile for the stay of an average patient of the same age with the same diagnosis. These averages are based on a 1969 study by the Commission on Professional and Hospital Activities of Ann Arbor (known as PAS[5]). Emergency cases in which the process is too long, are certified in a similar manner on the first working day following admission.

The Foundation has assigned registered nurses, referred to as certification coordinators, to each participating hospital with the mission of verifying the correctness of the certification request on each admission managed by CHAP and reviewing the need for medical services daily. Each participating physician is assigned to a "Foundation Advisor"—a local practicing physician responsible to the Foundation. If the coordinator determines the patient is receiving inappropriate care, she refers her contentions to the physician-advisor for possible discontinuance of coverage. Similarly, requests for extension of stay are evaluated by the advisor. Should a request be denied, the Foundation may appoint a consultant to review the case

In many instances, rejections occur because the care a patient has actually received has not been documented adequately; in some cases where payment has been denied, hospitals have encountered less than total cooperation when seeking additional data. In this instance, then, to assure some degree of equity in claims settlement, attending physicians must precisely document all services rendered and should lend their cooperative support in providing supplementary information when needed. As a particular hint to physicians with Medi-Cal patients, it was noted, requests for (and approval of) extensions of hospital stays should also be carefully documented in the patient's record.

UR in the Extended Care Facility

The subject of utilization review in the extended care facility (ECF) was discussed by Dr. James B. Conner, chairman of the Santa Barbara County Medical Society ECF UR Committee. This committee began its UR program in 1967. At first the entire committee made on-site visits to participating ECF's. This approach to UR quickly proved to be awkward, time-consuming, and inefficient, principally because of incomplete information. For a short time a system of review by mail only was attempted. Not unexpectedly, this method failed to provide effective review of the *quality* of care. Dr. Conner reported that his society's ECF UR Committee finally developed a highly satisfactory system for reviewing Medicare patients: Initial care evaluations and recommendations are made during on-site visits by an individual reviewer who is one of a large number of physicians forming a subcommittee of the parent body. The reviewer then transmits his findings to an executive committee which makes a final determination or may seek further information when necessary. To resolve the time-lag problem inherent in such proceedings, the current system has been refined so that the subcommittee member may disapprove patient stays on the spot when indicated, and the executive committee has been divided into two segments which meet alternately at one-week intervals. In addition, a full-time "utilization review coordinator" has helped to establish uniform procedures and provides essential coordination. Dr. Conner cited several advantages to this type of ECF UR program: (1) effective on-site evaluation of the entire range of medical services is accomplished while using the physician's time in a most efficient manner; (2) by simply adding additional operating units, this system can be easily expanded to serve a growing patient population or to cover nearly any geographic area; (3) the attending physician receives informal notification from the reviewer of an impending disapproval, thus providing opportunity for rebuttal and lessening the possibility of embarrassment; (4) delays are reduced to a minimum; and, further; (5) without a substantial increase in work-load, the committee can review more than just Medicare patients of extended duration. The Santa Barbara program has engendered a cooperative attitude in local physicians and increased their understanding of Medicare UR procedures. This has resulted from dealing with physicians on the basis of individual cases, through medical meetings and personal contacts, and through the medium of a monthly bulletin. The dissemination of information by attending physicians and ECF personnel to patients and their families has also led to a growing understanding by the lay public of limitations in Medicare benefits. These educational efforts are, of course, far from 100 percent successful, Dr. Conner said.

During the time the Santa Barbara ECF UR Committee has functioned, the speaker said, there has been a pronounced improvement in the quality of care provided in local ECF's. Medical records in these facilities are now better than before (with increased inter-facility uniformity), and patient care policies have been effectively refined. On the whole, the facilities have been cooperative and have shown respect for the committee, its reviewers, and the UR coordinator. There has been an increasing tendency for the various parties to discuss their problems together; inter-facility communication has become substantial and semi-annual meetings, attended by committee members and ECF personnel, have provided a convenient forum for airing complaints, discovering joint interests and developing common understanding. Recently, the ECF UR Committee prepared a report[3] summarizing its experiences and enumerating several positive recommendations relating to such programs. Dr. Conner related some of these suggestions at the finish of his presentation:

- The various, unrelated UR activities in a county or similar area should be consolidated and managed by a single coordinating entity such as the county medical society. Reviews of all types of patients in acute care hospitals, ECF's, home

if the attending physician so wishes. The advantage of this system, then, is that the physician—and his patient—knows before admission the extent of assured benefits. When requests for extension of stay approval are denied, or in instances in which the care a patient is receiving is deemed inappropriate, the attending physician has access to his peers for presentation of a rebuttal before termination of financial coverage. The Medical Care Foundation can thus pay all "approved" claims without resorting to retroactive denial for control of over-utilization. CHAP has succeeded in reducing average hospital stays by nearly one day for Medi-Cal and other patients covered by Medical Care Foundation plans.

Dr. Bramham, in taking up the question whether these reductions and other restrictive controls in CHAP might be inconsistent with the provision of high quality care, noted that savings in hospital days frequently are simply a matter of bringing utilization into line with contemporary medical practice. In addition he submitted that since insurance and government health programs have essentially provided a "credit card" for the consumer, demands for medical services can become insatiable unless managed by a system entailing authorization beforehand. Dr. Bramham proposed some simple guidelines for controlling medical care costs: (1) whenever possible, patients should be treated outside the hospital, (2) necessary hospitalization should be kept to a minimum, (3) a lower level of institutional care should be used whenever possible, (4) unnecessary diagnostic and surgical procedures and office visits should be avoided and (5) the least expensive satisfactory methods for diagnosis and treatment should always be made available to patients. Dr. said also that, whenever possible, the patient ought to pay himself for any unnecessary services he demands.

Because physicians are responsible for ordering or generating up to 80 percent of health care paid for under government and insurance programs, Dr. Bramham commented, the review of care must be extended beyond physicians' services if costs are to be limited. Further, to be totally effective, UR should be provided on as local a level as possible—effectiveness rapidly declines in proportion to the geographical distance separating reviewing and attending physicians. Dr. Bramham demonstrated that CHAP has done much to satisfy these essential requirements of a successful utilization review program.

The Fiscal Intermediary

The last to speak on specific aspects of utilization review was Dr. Carl E. Anderson, chairman of the board of California Blue Shield. He spoke briefly on the "role of the fiscal intermediary" in UR. Dr. Anderson pointed out that all facets of medicine are changing at a rapid—even alarming—pace. This observation, he said, is certainly as true for peer review as it is for medical technology and services. Recognizing the need to control costs, yet at the same time heed the responsibility of assuring that beneficiaries receive adequate care of a high quality, fiscal intermediaries have in recent years developed several innovative utilization review systems. Dr. Anderson said that medical audit programs, backed by the speed and enormous data-handling capacity of computers, will not, however, be able to reduce costs and concurrently assure the provision of quality medical care, unless practicing physicians continue and expand their own local review activities. Hence, Dr. Anderson said, the need for more thorough involvement of the medical profession in peer review programs. He stressed that Blue Shield would do all it could to encourage and support such efforts.

Panel Discussion

Following Dr. Anderson's remarks, a panel of all the proceeding speakers answered questions from the audience. Also sitting on the panel were Dr. Burt Davis, a member of the Board of Trustees of the American Medical Association and member of the Board of the Joint Commission for the Accreditation of Hospitals (JCAH), and Mr. Eric Leighton, executive director of the California Health Data Corporation (CHDC).

Dr. Davis was asked about the AMA's interest in utilization review. He replied that JCAH, of which AMA is a member, has insisted for some time that UR is one of the essential functions a hospital medical staff must perform. The AMA has always supported this position, but is now concerned with the prospect that the government might eventually monopolize UR programs by default if the medical profession did not vigorously support these activities at a state and local level.

Mr. Leighton, in response to several questions, outlined the role medical record data systems, such as the one developed by CHDC, could play in utilization review. CHDC is a San Francisco

based, non-profit corporation providing medical record abstracting and data processing services[6] (similar to those of the Professional Activity Study—PAS, of the Commission on Professional and Hospital Activities) for approximately 200 California acute care hospitals. It was established by CMA and the California Hospital Association to generate various types of health data.

This system, Mr. Leighton reported, could assist UR committees in evaluating in-hospital patient care trends, could routinely indicate unusual instances of utilization using an excepting-reporting format, and should encourage inter-hospital comparison of length-of-stay variations and medical treatment patterns. As an example of the latter, he reviewed a study done for the San Francisco Medical Society in which length-of-stay practices in several city hospitals were compared. Essentially, the system lends itself to retrospective review of individual cases, but can also produce statistically significant data on diagnosis-related length-of-stay for hospitals throughout the state. These California based stay norms will be vital in rationalizing and evaluating prior authorization programs for hospital admission such as CHAP or the one currently under consideration by the California State Department of Health Care Services for Medi-Cal patients.

Dr. Roberta Fenlon, president-elect of the California Medical Association, closed the conference by reviewing the remarks of the previous speakers and restating the urgent need for more effective UR programs based on the evaluation of physicians by their peers. Because UR is a relatively recent development in medical practice, there will continue to be wide regional, philosophic and political differences in its application. These variations should be encouraged to the end that this aspect of peer review will be based on local control with local decisions reflecting community medical practice. The profession must quickly energize all its resources so that it can give unequivocal assurances that the highest quality of medical care is being provided at a fair and reasonable cost to all patients, regardless of source of payment or financing. Dr. Fenlon concluded: "But we must remember that peer and utilization review originated with physicians to promote appropriate care for all patients; we must never allow government influence to fragment our effectiveness and thus jeopardize the quality of medical care for citizens of this state."

REFERENCES

1. Two related CMA publications: (a) Guidelines for Utilization Review; (b) Long-Term Care Review—A Statement of Principles. Available from California Medical Association, Division on Community Health, 693 Sutter Street, San Francisco, Ca. 94102

2. Schaffarzick RW, Parke HJ: Utilization and peer review—Medicine's privilege and responsibility. Calif Med 113: 80-85, Aug 1970

3. Santa Barbara County Medical Society: ECF/Utilization Review Committee Pilot Project Report. Available from the society, 900 Calle de los Amigos, Santa Barbara, Ca. 93105

4. Medical Care Foundation of the Sacramento County Medical Society: CHAP-Certified Hospital Admission Program. $1, available from the society, 5380 Elvas Avenue, Sacramento, Ca. 95819

5. Commission on Professional and Hospital Activities: Length of Stay in PAS Hospitals, United States, Pre- and Post-Medicare. Ann Arbor, Mich., 1969

6. Leighton E: MR1—The medical record system of the California Health Data Corporation. Medical Care 8(Supplement): 75-87, Jul-Aug 1970

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